water. As a general rule, I should, on account of the pallor of the countenance, abstain from bleeding."—*Med. Chir. Rev.*, Jan., from *Gazette Médicale*, No. 47.

18. *Obliteration of the Vena Cava Descendens.*—Dr. Carson presented to the Newton Branch of the Prov. Med. and Surg. Assoc. for their examination, a labourer in a soap manufactory, exposed in his work to sudden and great vicissitudes of temperature, in whom, in the end of last August, after a severe lancinating pain, extending from a point beneath the fourth rib, upon the right side, near the sternum, to a corresponding point behind upon the same level, between the base of the scapula and the spine, increased by full inspiration, and accompanied with a hard dry cough, rigors and fever flushes, there was gradually developed œdema of the head and neck, upper extremities, and of the upper parts of the chest, and unusual dilatation of the superficial veins of these parts, and of the rest of the trunk of the body. These symptoms were attended with sense of fulness in the head and neck, buzzing of the ears, and flashes of light before the eyes, difficulty of breathing except in the erect position, and inability to lie upon the left side, in consequence of which the œdema was most remarkable upon the right side. There were no indications from auscultation, of disease in the lungs, heart, or large blood-vessels of the chest, with the exception of a large moist crepitus at the base of the right lung, indicating an œdematous condition of its tissue. There was no dilatation of the veins, or œdema of the lower extremities.

From the use of moderate antiphlogistic treatment, diuretics, and from the comforts of the hospital, all these symptoms gradually subsided, with the exception of the dilated condition of the veins, which was rather more marked in consequence of the subsidence of the œdema. The last symptom that was mitigated was the sense of fulness in the head and neck, which in some degree still continues when he suddenly stoops down. In consequence of returning too soon to his work, and of the severity of the weather, he was attacked with catarrh and a return of the symptoms; which, however, under similar treatment, shortly subsided, and he has continued in good health up to the present day, still able to work. He has no difficulty of breathing in walking fast or up hill, and the sense of fulness in the head is only troublesome when he stoops down. His present appearance is that of a man in robust health; there is a dark hue in the complexion, increased when he stoops down, and there is a very dilated condition of the veins of the forehead, neck, upper extremities, and of the trunk of the body, particularly on the anterior surface. Large veins as thick as a swan's quill proceed from above the upper edge of the clavicle, and from the axilla over the anterior surface of the thorax, in a tolerably straight course, to a *tortuous* cluster of veins in the epigastrium, from which emanate a number of veins running in a straight uncontorted course to the groin, the latter being rather thicker than those coming from the neck and axilla. The course of the blood in all these veins is from above, downwards.

Dr. Carson inferred the existence of obliteration of the vena cava descendens, between the entrance of the azygos vein and the right auricle, and the consequent return of all the venous blood of the body to the heart by the ascending cava. The return of the venous blood to the heart from the head, neck, upper extremities, and the walls of the chest, he inferred to take place by a retrograde course through the dilated superficial veins of the chest, the deep-seated plexus of veins surrounding and within the spinal column, through the internal mammary, intercostal, azygos, and superior diaphragmatic veins, and from these by a direct course through the inferior diaphragmatic, lumbar, demiazygos, superficial and deep-seated epigastric veins, pouring their blood into the ascending cava directly, and into the renal and iliac veins. The obliteration of the cava between the azygos vein and the right auricle, is inferred from the seat of the pain, and from the tortuous condition of the large cluster of veins at the epigastrium, and beneath the edges of the ribs, for a few inches on each side of it. The plexus of superficial and deep-seated veins of the chest, at and around the epigastrium, are evacuated into the superficial axillary, the external and internal mammary, the superior and inferior diaphragmatic and the superficial and deep-seated epigastric veins. If the passage to the heart through the azygos veins of the venous blood from the walls of the chest be cut off, the pressure upon the veins at the epigastrium must be increased, and hence their tortuousity, which may therefore be considered, in con-

formity with Dr. Watson's views, as a test of the portion of the cava obliterated. If this inference be correct, the present case is precisely similar to that described by Dr. Reid, in the 43d volume of the *Edinburgh Medical and Surgical Journal*, and the appearances discovered by him in the body of his patient, dead from other causes, may be a guide in determining the cause and prognosis in the present case. There is nothing in the obliteration of either of the cavæ, provided it take place gradually, which would of itself lead to an unfavourable prognosis, but in the great majority of the cases on record, the obliteration has depended upon aneurismal or other tumours, which have been the cause of a fatal result. In Dr. Reid's case, the obliteration appears to have resulted from enlargement of the bronchial glands, from inflammation, which had obliterated the cavity of the vein by pressure upon its walls. Dr. Carson was inclined to a favourable prognosis in the present case, as he did not consider it probable that an aneurism of the ascending aorta, in such a position as would produce obliteration of the cava in the given position, would remain latent and undiscovered by the ordinary modes of investigation, for so long a period. The healthy appearance of the patient precludes the idea of a malignant tumour. The only other explanation would be that of a local phlebitis, whose presence was indicated by the pain. The retrograde course of the blood in the veins, in spite of the valves, was considered by Dr. Carson to be explicable by the circumstance of there being, with few unimportant exceptions, no valves in the veins of the trunk of the body.—*Prov. Med. and Surg. Journ.*, Aug. 5th, 1846.

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19. *Treatment of Chronic Bronchitis and Bronchial Asthma.*—Dr. Theophilus Thompson, in a paper read before the Medical Society of London, invited the attention of the society to a class of cases claiming our careful study in consequence of their frequent occurrence, and their injurious influence on the constitution, often occasioning disease of the heart, or, especially when extending throughout the ultimate pulmonary ramifications, tending to the production of dropsy. Amongst the applicants for relief at the Hospital for Consumption and Diseases of the Lungs, he stated that a very large proportion are affected with chronic bronchitis, in the form which Dr. Thompson proceeded to describe. They present themselves with respiration, a little wheezing, and somewhat hurried by exertion; their complexion in some degree affected by partail deficiency of oxygen, often without pain of chest, or acceleration of pulse, but with inspiration rather laborious, and expiration prolonged. On listening to the chest, the respiratory murmur is found to be more or less extensively superseded by mucous rhonchus, commonly intermixed with the sonorous and sibilant. The sleep of such patients is usually disturbed. Those possessing much peculiar nervous susceptibility are liable to distinct paroxysms of asthma, often occurring an hour or two after retiring to rest. If you inquire how long the complaint has lasted, some will tell you many winters, others, that they have never been quite right for many years. They have tried various treatment with temporary effect; but on the whole lose ground, and are unfit for active duty. The heart becomes oppressed and dilated, and they die eventually either from the supervention of acute bronchitis, or from dropsy; or if beyond the meridian of life, not unfrequently in a few years, they become consumptive. Dr. Thompson proceeded to notice the remedial treatment recommended by authors, and to show that the results were too often unsatisfactory. Antimony given alone is not altogether useless; but it is inadequate, and may be carried to such an extent as to injure the constitution, without permanently improving the condition of the tubes. Counter-irritation, although strongly recommended, produces only temporary advantage, and superadds to a trying malady a painful annoyance. Acids check expectoration, and often occasion tightness of chest. Opiates, so often given to allay the incidental cough, not infrequently induce severe pleurodyne. The plan which Dr. Thompson first adopted, some years ago, he has, with certain modifications, very extensively employed at the Hospital for Consumption and Diseases of the Lungs, as well as in private practice, and the results have been so gratifying, as to make him anxious to communicate them to the Society. It consisted mainly in establishing on the bronchial tubes, gently, but rather rapidly, the influence of mercury. Calomel is undesirable, since if given freely it will frequently salivate, and its discontinuance be required before the bronchial condition is materially